North Central Accountable
Community of Health

Whole Person Care Collaborative (NCACH) Agenda

11:00 AM – 12:50 PM Monday November 6, 2017

Confluence Technology Center 285 Technology Center Way #102 Wenatchee, WA 98801	Conference Dial-in Number: (408) 638-0968 or (646) 876-9923 Meeting ID: 429 968 472# *Join from PC, Mac, Linux, iOS or Android: <https://zoom.us/j/429968472>*

Proposed Agenda	**Time**	**Goals**
1. Introduction Peter Morgan	11:00	• Introductions and Roll Call • Approve Agenda and Minutes • Follow up items from last meeting

2. Learning Collaborative Project Planning
Connie Davis- CCMI
	11:15	• Project Design Phase Description
		  ○ Project proposal update & goals for site visit
		  ○ Why use a learning collaborative?
		    ▪ Goals, process, experience, expectations
		    ▪ Project team and use of other consultants
		    ▪ Designing the collaborative to fit the NCACH
		  ○ Q & A & Collective Advice

3. WPCC project outcomes and targets Caroline Tillier Peter Morgan	12:05	• Review ACH data and targeted opportunities for improvement to be addressed by WPCC • Discuss and comment on improvement priorities to be addressed.

4. Demonstration Project Update:
John Schapman
Linda Parlette
Barry Kling
	12:15	• Update Committee on Demonstration Project Timelines:
		  ○ Inter-relationship between NCACH projects
		  ○ Domain 1 projects on HIT, Workforce Planning
		  ○ Proposed focus group on Social Determinants

5. Other Announcements: Peter Morgan John Schapman	12:35	• Learning Opportunities • TBD • Identify Next Steps
6. Adjourn	12:45	

Bi-Directional Integration of Physical and Behavioral Health through Care Transformation | Chronic Disease Prevention and Control (Pay for Performance)

Measure Name *(bolded measures start in 2020 - all others start in 2019)*	Measure Description	Method for Assessment of ACH Performance	Reporting Responsibility	Measurement Period	Source	ACH Performance	Chelan	Douglas	Grant	Okanogan	Statewide	Highest Performing ACH	Lowest Performing ACH	National 90th percentile	National 75th percentile	National Average
Antidepressant Medication Management - Acute	The percentage of Medicaid enrollees 18 years of age and older with a diagnosis of major depression and were newly treated with antidepressant medication.	Gap to Goal	HCA	Oct 2015 - Sept 2016	HW Data Dashboard	**48%**	49%	50%	50%	43%	52%	55%	48%			54.5% (2016)
Antidepressant Medication Management - Continuation	The percentage of Medicaid enrollees 18 years of age and older with a diagnosis of major depression and were newly treated with antidepressant medication, and who remained on an antidepressant medication treatment.	Gap to Goal	HCA	Oct 2015 - Sept 2016	HW Data Dashboard	**29%**	29%	27%	30%	26%	33%	37%	29%			39.5% (2016)
Child and Adolescents' Access to Primary Care Pracitioners (all ages)	Percent of children enrolled in Medicaid who had a visit with a primary care provider.	Gap to Goal	HCA	Oct 2015 - Sept 2016	HW Data Dashboard	**93%**	92%	93%	94%	90%	89%	93%	85%		93.7% (2015)	N/A
Child and Adolescents' Access to Primary Care Practitioners (ages 12-24 months)	Percent of children enrolled in Medicaid who had a visit with a primary care provider.	Gap to Goal	HCA	Oct 2015 - Sept 2016	HW Data Dashboard	**95%**	94%	96%	96%	93%	94%	95%	89%		97.4% (2015)	94.7% (2016)
Child and Adolescents' Access to Primary Care Practitioners (ages 2 - 6 years)	Percent of children enrolled in Medicaid who had a visit with a primary care provider.	Gap to Goal	HCA	Oct 2015 - Sept 2016	HW Data Dashboard	**89%**	87%	90%	91%	85%	86%	89%	81%		91.2% (2015)	87.2% (2016)
Child and Adolescents' Access to Primary Care Practitioners (ages 7 - 11 years)	Percent of children enrolled in Medicaid who had a visit with a primary care provider.	Gap to Goal	HCA	Oct 2015 - Sept 2016	HW Data Dashboard	**94%**	93%	94%	95%	92%	91%	94%	87%		93.9% (2015)	90.2% (2016)
Child and Adolescents' Access to Primary Care Practitioners (ages 12 - 19 years)	Percent of children enrolled in Medicaid who had a visit with a primary care provider.	Gap to Goal	HCA	Oct 2015 - Sept 2016	HW Data Dashboard	**95%**	94%	95%	95%	93%	90%	95%	86%		92.4% (2015)	88.6% (2016)
Comprehensive Diabetes Care: Eye Exam (retinal) performed	Percentage of Medicaid enrollees 18-75 years of age with diabetes who had a retinal or dilated eye exam by an eye care professional during the measurement period or a negative retinal exam (no evidence of retinopathy) in the 12 months prior to the measurement period.	Gap to Goal	HCA	Oct 2015 - Sept 2016	HW Data Dashboard	**45%**	44%	46%	41%	51%	31%	45%	24%	70%	64%	52.7% (2016)
Comprehensive Diabetes Care: HbA1c Testing	Percentage of Medicaid enrollees 18-75 years of age with diabetes (type 1 and type 2) who received an HbA1c test during the measurement year.	Gap to Goal	HCA	Oct 2015 - Sept 2016	HW Data Dashboard	**87%**	88%	86%	87%	87%	84%	87%	81%	91%	87%	86.0% (2016)
Comprehensive Diabetes Care: Medical attention for nephropathy	The percentage of Medicaid enrollees 18–75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy during the measurement period.	Gap to Goal	HCA	Oct 2015 - Sept 2016	HW Data Dashboard	**88%**	88%	84%	89%	88%	86%	88%	83%	87%	83%	90.0% (2016)

Follow-up After Discharge from ED for Mental Health (30 day)	The percentage of discharges for Medicaid enrollees 18 years of age and older who had a visit to the emergency department with a primary diagnosis of alcohol or other drug dependence during the measurement year AND who had a follow-up visit with any provider with a corresponding primary diagnosis of alcohol or other drug dependence. Two rates are reported: (1) The percentage of discharges for enrollees who received follow-up within 30 days of discharge; (2) The percentage of discharges for enrollees who received follow-up within 7 days of discharge.	Gap to Goal	RDA	CY 2016	HCA Historical Data File	**83.9%**	n/a	n/a	n/a	n/a	70.2%	84%	62.7%			
Follow-up After Discharge from ED for Mental Health (7 day)		Gap to Goal	RDA	CY 2016	HCA Historical Data File	**77.3%**	n/a	n/a	n/a	n/a	58.7%	77%	45.3%			
Follow-up After Discharge from ED for Alcohol or Other Drug Dependence (30 day)	The percentage of discharges for Medicaid enrollees 18 years of age and older who had a visit to the emergency department with a primary diagnosis of mental health during the measurement year AND who had a follow-up visit with any provider with a corresponding primary diagnosis of mental health. Two rates are reported: (1) The percentage of discharges for enrollees who received follow-up within 30 days of discharge; (2) The percentage of discharges for enrollees who received follow-up within 7 days of discharge.	Gap to Goal	RDA	CY 2016	HCA Historical Data File	**30.6%**	n/a	n/a	n/a	n/a	28.0%	38.0%	23.7%			
Follow-up After Discharge from ED for Alcohol or Other Drug Dependence (7 day)		Gap to Goal	RDA	CY 2016	HCA Historical Data File	**24.5%**	n/a	n/a	n/a	n/a	20.6%	30.6%	15.5%			
Follow-up After Hospitalization for Mental Illness (30 day)	The percentage of discharges for Medicaid enrollees 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported: (1) The percentage of discharges for enrollees who received follow-up within 30 days of discharge; (2) The percentage of discharges the enrollees who received follow-up within 7 days of discharge.	Gap to Goal	RDA	CY 2015	RDA Measure Decomposition	**88.9%**	n/a	n/a	n/a	n/a	79.8%	89%	71.0%			61.2% (2016)
Follow-up After Hospitalization for Mental Illness (7 day)		Gap to Goal	RDA	CY 2015	RDA Measure Decomposition	**76.7%**	n/a	n/a	n/a	n/a	65.8%	76.8%	53.7%	70%	58%	43.6% (2016)
Inpatient Hospital Utilization	For members 18 years of age and older, the risk-adjusted ratio of observed to expected acute inpatient discharges during the mesaurement year reported by Surgery, Medicine, and Total	Improvement over self	HCA			**N/A**										
Medication Management for People with Asthma (5 – 64 Years)	The percentage of Medicaid enrollees 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period.	Gap to Goal	HCA	Oct 2015 - Sept 2016	HW Data Dashboard	**23%**	19%	22%	22%	32%	28%	32%	23%	43%	36%	32.8% (2016)

Bi-Directional Integration of Physical and Behavioral Health through Care Transformation |
Chronic Disease Prevention and Control
(Pay for Performance)

Mental Health Treatment Penetration (broad)	Percent of Medicaid enrollees with a mental health service need who received at least one qualifying service during the measurement year. Separate reporting by age groups: 12-17 years and 18-64 years	Improvement over self	RDA	2015	HCA Historical Data File	**40.5%**	n/a	n/a	n/a	n/a	42.9%	47.0%	40.2%	N/A	N/A	N/A
Outpatient Emergency Department Visits per 1000 Member Months (*Broad measure*)	The rate of Medicaid enrollee visits to emergency department per 1000 member months, including visits related to mental health and chemical dependency. Separate reporting for age groups 10-17, 18-64, and 65+.	Improvement over self	HCA	Oct 2015 - Sept 2016	HW Data Dashboard	**40**	39	37	39	44	54	40	72	N/A	N/A	N/A
Plan All-Cause Readmission Rate (30 Days)	The proportion of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission within 30 days among Medicaid enrollees ages 18-64 years old.	Gap to Goal	RDA	July 2015 - June 2016	HW Data Dashboard	**10%**	13%	10%	11%	6%	15%	10%	17%			
Substance Use Disorder Treatment Penetration	The percentage of Medicaid enrollees with a substance use disorder treatment need who received substance use disorder treatment in the measurement year. Separate reporting by age groups: 12-17 years and 18-64 years.	Improvement over self	RDA	2015	HCA Historical Data File	**22.2%**	n/a	n/a	n/a	n/a	26.7%	30.3%	21.4%	N/A	N/A	N/A
Statin Therapy for Patients with Cardiovascular Disease (Prescribed)	Percentage of male Medicaid enrollees 21 to 75 years of age and female Medicaid members 40 to 75 years of age during the measurement year who were identified as having clinical ASCVD who were dispensed at least one high- or moderate-intensity statin medication.	Improvement over self	HCA	FY 2015	Community Checkup	**14%**	n/a	n/a	n/a	n/a	20%	27%	14%			

Projects ⇨	**Bi-Directional Integration of Physical and Behavioral Health through Care Transformation**	**Chronic Disease Prevention and Control**
Objective	Through a whole-person approach to care, address physical and behavioral health needs in one system through an integrated network of providers.	Integrate health system and community approaches to improve chronic disease management and control.
General target population (as defined by HCA)	All Medicaid beneficiaries (children and adults) **particularly those with or at-risk for behavioral health conditions**, including mental illness and/or substance use disorder (SUD).	Medicaid beneficiaries (adults and children) with, or at risk for, arthritis, cancer, chronic respiratory disease (asthma), diabetes, heart disease, obesity and stroke, with a **focus on those populations experiencing the greatest burden of chronic disease(s) in the region**.
Accountability Metrics (Pay for Performance)	Antidepressant Medication Management	
	Child and Adolescents' Access to Primary Care Practitioners	Child and Adolescents' Access to Primary Care Practitioners
	Comprehensive Diabetes Care: Eye Exam (retinal) performed	Comprehensive Diabetes Care: Eye Exam (retinal) performed
	Comprehensive Diabetes Care: Hemoglobin A1c Testing	Comprehensive Diabetes Care: Hemoglobin A1c Testing
	Comprehensive Diabetes Care: Medical Attention for Nephropathy	Comprehensive Diabetes Care: Medical Attention for Nephropathy
	Depression Screening and Follow-up for Adolescents and Adults *Metric in process of being dropped*	
	Follow-up After Discharge from ED for Mental Health (7 and 30 day measures)	
	Follow-up After Discharge from ED for Alcohol or Other Drug Dependence (7 and 30 day measures)	
	Follow-up After Hospitalization for Mental Illness	
	Inpatient Hospital Utilization	Inpatient Hospital Utilization
	Medication Management for People with Asthma (5 – 64 Years)	Medication Management for People with Asthma (5 – 64 Years)
	Mental Health Treatment Penetration (Broad Version)	
	Outpatient Emergency Department Visits per 1000 Member Months	Outpatient Emergency Department Visits per 1000 Member Months
	Plan All-Cause Readmission Rate (30 Days)	
	Substance Use Disorder Treatment Penetration	
		Statin Therapy for Patients with Cardiovascular Disease (Prescribed)

Created 10/30/2017

Other Project Measures

WPCC may interact with the following other projects. Bolded measures are not already covered by bi-directional integration and chronic disease prevention/control.

MEASURES ⇩ / PROJECTS ⇨	Community-Based Care Coordination	Transitional Care	Diversion Interventions	Addressing Opioid Use
Outpatient Emergency Department Visits per 1000 member months	x	x	x	x
Inpatient Hospital Utilization	x	x		x
Percent Homeless (Narrow definition)	x	x	x	
Follow-up After Discharge from ED for Mental Health, Alcohol or Other Drug Dependence	x	x		
Follow-up After Hospitalization for Mental Illness	x	x		
Plan All-Cause Readmission Rate (30 Days)	x	x		
Mental Health Treatment Penetration (Broad Version)	x			
Substance Use Disorder Treatment Penetration	x			
Percent Arrested			x	
Patients on high-dose chronic opioid therapy by varying thresholds				x
Patients with concurrent sedatives prescriptions				x
Substance Use Disorder Treatment Penetration (Opioid)				x
Medication Assisted Therapy (MAT): With Buprenorphine or Methadone *Metrics in process of being dropped*				x